




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [swhp.org/plandocs](http://swhp.org/plandocs) call 1-800-321-7947. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call 1-800-321-7947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,000 individual / \$4,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , <a href="#">urgent care</a> , office visits, pediatric eye exam, and <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,000 individual / \$8,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://swhp.org">swhp.org</a> or call 1-800-321-7947 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	Not covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	Imaging (CT/PET scans, MRIs)	20% of charges; <a href="#">deductible</a> does not apply	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">swhp.org/en-us/members/manage-your-plan/pharmacy-information</a> .	ACA Preventive Drugs	\$0 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply/prescription.	Not covered	<a href="#">Copays</a> are per 30-day supply. Maintenance-eligible drugs are allowed up to a 90-day supply for 2.5 <a href="#">copays</a> if obtained through a Baylor Scott & White Pharmacy or participating 90-day retail or mail order pharmacy provider. Mail Order: Available for a 1 to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Some <a href="#">Specialty drugs</a> may require prior authorization. 30-day supply only. Chronic preventive medications are not subject to <a href="#">deductible</a> .
	Tier 1: Preferred Generic Drugs	\$10 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply/prescription.	Not covered	
	Tier 2: Preferred Brand Name Drugs	\$45 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply/prescription.	Not covered	
	Tier 3: Non-Preferred Generic / Brand Name Drugs	\$85 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply/prescription.	Not covered	
	<a href="#">Specialty Drugs</a>	T1: 15%/prescription. T2: 15%/prescription. T3: 25%/prescription. <a href="#">Deductible</a> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% after <a href="#">deductible</a>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% after <u>deductible</u>	Not covered	at 1-800-321-7947.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <u>copay</u> /visit, then 20% of charges. <u>Deductible</u> does not apply.	\$250 <u>copay</u> /visit, then 20% of charges. <u>Deductible</u> does not apply.	<a href="#">Copay</a> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.
	<a href="#">Emergency medical transportation</a>	20% after <u>deductible</u>	20% after <u>deductible</u>	None
	<a href="#">Urgent care</a>	\$75 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$75 <u>copay</u> /visit. <u>Deductible</u> does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after <u>deductible</u>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	Physician/surgeon fees	20% after <u>deductible</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> /visit. <u>Deductible</u> does not apply. 20% after <u>deductible</u> for all other services.	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	Inpatient services	20% after <u>deductible</u>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
If you are pregnant	Office visits	\$50 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% after <u>deductible</u>	Not covered	The health plan must be notified of the delivery. If a length of stay for an uncomplicated delivery exceeds 48 hours for vaginal, or 96 hours for caesarean, <a href="#">preauthorization</a> is required. Failure to notify or <a href="#">preauthorize</a> , when required, may result of a
	Childbirth/delivery facility services	20% after <u>deductible</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				denial of the service. Refer to <a href="http://swhp.org">swhp.org</a> or Customer Service at 1-800-321-7947.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% after <u>deductible</u>	Not covered	Limited to 60 visits per <a href="#">plan</a> year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Rehabilitation services</a>	\$50 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not covered	Limited to 35 visits per <a href="#">plan</a> year. Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Habilitation services</a>	\$50 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not covered	Limited to 35 visits per <a href="#">plan</a> year. Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Skilled nursing care</a>	20% after <u>deductible</u>	Not covered	Limited to 25 days per <a href="#">plan</a> year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Durable medical equipment</a>	50% after <u>deductible</u>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Hospice services</a>	No Charge	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://swhp.org">swhp.org</a> or Customer Service at 1-800-321-7947.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$50 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not covered	Limited to one eye exam per <a href="#">plan</a> year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care (Adult and Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care (Limited to 35 visits per [plan](#) year)
- Hearing aids (Limited to one per ear every three years for covered members 18 years of age or younger)
- Routine eye care (Adult) (Limited to an annual eye exam conducted by a licensed ophthalmologist or optometrist)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Scott & White Care Plans, visit [swhp.org](#), or call 1-800-321-7947; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](#). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [HealthCare.gov](#) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Scott & White Care Plans, visit [swhp.org](#), or call 1-800-321-7947; Texas Department of Insurance, visit [tdi.texas.gov](#) or call 1-800-578-4677; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](#), Texas Department of Insurance Texas Health Options at 1-800-252-3439 or [texashealthoptions.com](#).

### Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-321-7947.

————— *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,060</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,380
<a href="#">Copayments</a>	\$1,040
<a href="#">Coinsurance</a>	\$350
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,830</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,100
<a href="#">Copayments</a>	\$350
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,750</b>

# Nondiscrimination Notice

---



ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Scott & White Care Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Scott & White Care Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Scott & White Care Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Scott & White Care Plans Compliance Officer at 1-214-820-8888 or send an email to [SWHPComplianceDepartment@BSWHealth.org](mailto:SWHPComplianceDepartment@BSWHealth.org)

If you believe that Scott & White Care Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Scott & White Care Plans, Compliance Officer  
1206 West Campus Drive, Suite 151  
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or <https://app.mycompliancereport.com/report.aspx?cid=swhp>

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.

**English:**

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

**Spanish:**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 711).

**Vietnamese:**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-321-7947 (TTY: 711).

**Chinese:**

注意: 如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-800-321-7947(TTY:711)。

**Korean:**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 711) 번으로 전화해 주십시오.

**Arabic:**

هاتف الصم والبكم: 711. ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم 800-321-7947-1)

**Urdu:**

کریں۔ (1-800-321-7947 (TTY: 711) خیردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال

**Tagalog:**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 711).

**French:**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

**Hindi:**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 711) पर कॉल करें।

**Persian:**

فراهم می باشد. با 1-800-321-7947 (TTY: 711) تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

**German:**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 711).

**Gujarati:**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

**Russian:**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 711).

**Japanese:**

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-321-7947 (TTY:711)まで、お電話にてご連絡ください。

**Laotian:**

ໂປດຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອ ວ່າ ພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຈະ ສາມາດ ຄ່າ ນຳ ສຳ ຫຼັບ ທ່ານ. ໂທ 1-800-321-7947 (TTY: 711).